Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**

- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**

- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: __District of Columbia_____
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

_____
(Signature of Agency Head)

SCHIP Program Name(s): _D.C. Healthy Families_____

SCHIP Program Type:
_X__Medicaid SCHIP Expansion Only
_____Separate SCHIP Program Only
_____Combination of the above

Reporting Period: Federal Fiscal Year 2001 (10/1/2000-9/30/2001)

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Submission Date: January 18, 2001

(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002)
Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. Program eligibility **NC**

B. Enrollment process **NC**

C. Presumptive eligibility **NC**

D. Continuous eligibility **NC**

E. Outreach/marketing campaigns

- **Response:** Outreach for SCHIP has changed considerably in late FY 2001. Due to the increase in the numbers of Washingtonians displaced as a result of the unexpected decrease of business in the hospitality and tourism industries in September, D.C. Healthy Families modified the way in which outreach is done. Additionally, the types of consumers targeted have changed, requiring us to tweak our marketing strategies. We retained partnerships with over 800 organizations, including businesses, community-based organizations, public, private and charter schools, and day care providers. Applications are still available at each of these sites. The public is also directed to convenient locations that are accessible during the course of their workday through media announcements about D.C. Healthy Families. Some of those locations include: CVS/Pharmacy, RiteAid, Giant, Safeway, local libraries, Department of Motor Vehicles Service Centers, employment centers, Department of Health sites, the Housing Department and the Tax and Revenue office. We also continue to work with the three community based Covering Kids sites and the Not-for-Profit Clinic Consortium—(5) sites. All of those locations provide applications and on-site face-to-face assistance. Managed care organizations (MCOs) have also partnered to support hundreds of community events, direct mail and radio/print advertisements.

F. Eligibility determination process **NC**

G. Eligibility redetermination process **NC**

H. Benefit structure **NC**

I. Cost-sharing policies **NC**

J. Crowd-out policies **NC**

K. Delivery system **NC**

L. Coordination with other programs (especially private insurance and Medicaid) **NC**

M. Screen and enroll process **NC**

N. Application **NC**

O. Other **NC**

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

Response: The total DC CHIP enrollment for FFY 2001 is 2807. This data was extracted from the ACEDS eligibility and MMIS systems. Calculations are based on the ACEDS Eligibility System, with a breakout of SCHIP program codes.

B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

Response: The total DC CHIP and Medicaid enrollments for FFY 2001 are 2807 and 60,919 respectively. Calculations are based on the ACEDS Eligibility System, with a breakout of SCHIP program codes.

C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

Response: The total number of newly enrolled children in FFY 2001 was 2807.

D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

__X__ No, skip to 1.3

____ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2: List the performance goals for each strategic objective.
Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3*.

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Objectives related to Reducing the Number of Uninsured Children		
The District did not have a strategic objective for this category.	Monitor number of children who were previously (pre-expansion) eligible but not enrolled in the Medicaid program on a monthly basis.	Data Sources: N/C Methodology: N/C Progress Summary: N/C
Objectives Related to SCHIP Enrollment		
The District will achieve at least 5 percent of its projected enrollment of CHIP eligible children within the first year of implementation of the eligibility expansion.	The District will collect data on the number of CHIP-eligible children enrolled in the program on a monthly basis.	Data Sources: N/C Methodology: N/C Progress Summary: The District has been working collaboratively with the DC Primary Care Association to fund a study of CHIP and Medicaid eligible children. This study will enable the District to make reliable forecasts and enrollment predictions. This project is currently in progress.
Objectives Related to Increasing Medicaid Enrollment		
Within the first year of the eligibility expansion and its associated outreach strategy, the District will identify and enroll at least 35 percent of those children who are Medicaid-eligible but not enrolled.	The District will collect data on the number of Medicaid-eligible children enrolled in the program on a monthly basis.	Data Sources: N/C Methodology: N/C Progress Summary: The District has been working collaboratively with the DC Primary Care Association to fund a study of CHIP and Medicaid eligible children. This study will enable the District to make reliable forecasts and enrollment predictions. This project is currently in progress.
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
Fifty percent of CHIP-enrolled children will have self-selected an HMO and a primary care provider within the first year of enrollment	The District will monitor monthly data on CHIP enrollees and whether or not they were voluntary selections.	Data Sources: N/C Methodology: N/C Progress Summary: The District continues to monitor voluntary HMO/MCO and PCP selections weekly and monthly. Voluntary HMO/MCO selection has consistently been around 76%. PCP selection has recently increased to 80%, up from 65%.
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
The District did not have a strategic objective for this category.	The District monitors utilization of preventive services through HMO mandatory reporting mechanisms.	Data Sources: N/C Methodology: N/C

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Progress Summary: N/C
Other Objectives		
Those newly enrolled in CHIP and Medicaid will express satisfaction with the new enrollment process. The District will develop and implement a process for determining the effectiveness of (a) the enrollment process, and (b) the Citywide outreach strategy.	The District will capture information related to consumer satisfaction with the eligibility determination process through its managed care enrollment broker. The District will work through its managed care enrollment broker (and others) to elicit information from customers related to satisfaction with the eligibility determination process.	Data Sources: N/C Methodology: N/C Progress Summary: Focus groups are held to continue to capture a broader picture of consumer satisfaction.

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

Response: N/A

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

Response: N/A

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Response: N/A

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

Response: See attached packet.

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

Response: Family coverage is provided for parents and caretakers of SCHIP children through the District of Columbia's expansion. Parents and caretakers must also meet the income guidelines for program participation. The parent or caretaker is actually identified as the head of household for the "case" and all individuals within the case are encouraged to join the same MCO. Redetermination rules are the same for SCHIP children and parents/caretakers. Additionally, the same rules for crowd applies to SCHIP children and parents/caretakers.

B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

1762 Number of adults
2807 Number of children

C. How do you monitor cost-effectiveness of family coverage?

Response: Providing health insurance to any uninsured person will eventually prove to be cost effective. People who have access to health care are more inclined to practice preventive care, therefore reducing the need for acute treatment. Additionally, preventive care is less costly than acute care.

2.2 Employer-sponsored insurance buy-in:

A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

Response: N/A

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

Response: N/A

_N/A Number of adults
_N/A Number of children

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

Response: Within the District of Columbia, crowd-out in the SCHIP program would simply mean recipients with current health insurance, or who are capable of purchasing health insurance, electing to participate in SCHIP so as not to have to pay any premiums or copays.

B. How do you monitor and measure whether crowd-out is occurring?

Response: Crowd-out is prevented by screening during the eligibility determination Process when the applicant is asked whether or not they have other insurance.

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

Response: The District has represented to the Federal government that it will monitor responses to this inquiry and develop a more proactive policy should the number of positive responses exceed 10 percent of all Title XXI children. Fifteen percent of all individuals who applied checked the box stating that they had dropped health insurance within three months of applying for DC Healthy Families. The District is unable to report on the percentage of those who checked the box were ultimately eligible for and enrolled in the Title XXI expansion although we suspect that not all individuals who stated that they dropped insurance actually were enrolled. The District is in the process of trying to identify a way to track not only how many dropped insurance but also how many of those who dropped insurance are ultimately enrolled.

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

Response: The District of Columbia does not have any set crowd-out policies and again relies on the Income Maintenance Administration (IMA) to screen for crowd-out during the eligibility determination process.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

Response: The outreach activities that have been most effective in reaching this population include:

General Public

I. Radio, print and transit advertisements have been strategically placed throughout the city in

locations that are accessible to diverse populations in their communities and where they work.

II. Partnerships with schools, such as: special events designed to reach the parents of school-aged children (poster/poetry contest, back-to-school nights, school lunch application, assemblies, Parent Expos and orientations.)
III. Street outreach, face-to-face contact with employers and potential eligibles on their way to/from work.
IV. 1-800-health line answers questions, provides one-on-one assistance and follows-up with callers.
V. Widely accessible application distribution sites throughout the city.
VI. Printed materials that are attractive and emphasize health prevention, wellness, caring and hassle-free enrollment into the program.
VII. Partnerships with over 800 community-based organizations and welfare-to-work contractors.

Special Populations

I. On-site outreach workers at not-for-profit clinics that currently serve immigrant populations.
II. Use of flyers in many languages such as French, Spanish, Lao, Vietnamese, Mandarin and Amaric.
III. Applications in English and Spanish.
IV. District's expansion initiative to enroll (500) non-citizen children
V. TTY line and marketing to hearing impaired organizations
VI. Street outreach efforts to local businesses throughout the immigrant community
VII. Face-to-face marketing (small business employers)
VIII. Community training
IX. Targeted advertisements in ethnic newspapers, radio and TV

Process evaluation is used to determine effectiveness of outreach efforts throughout each phase of the project. This method of evaluation also ensures feasibility to determine costs, materials and labor in relation to actual numbers enrolled. In many cases we can evaluate what is working? what isn't working – and to re-tool strategy early on without wasting needed dollars.

Each of the following program components is evaluated individually and cumulatively as it relates to number of enrollees.

1. Health line: Statistics are collected monthly on the number of calls, wards of the city, male/female, language, call hang-up and complaints.
2. Training: Number of persons trained per month and results from written evaluations.
3. Outreach: Number of persons that receive information on-site, complete applications, mail-in applications and/or requests further assistance.
4. Distribution: Number of applications requested per month, number of applications approved monthly and site of origination.
5. Special events: Number of persons in attendance, number of applications received following an event, number of requests received for applications, number of calls to health line.

Media/Advertisements: Number of persons reached, number of calls to health line, number of approved applications, number of applications distributed. Effectiveness has been measured by the increase in call center volume reports and subsequently an increase in enrollments for that period of time.

B. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

Response: Numerous strategies have been used to educate families about D.C. Healthy Families and enroll eligible children into the program. These strategies include:

- Health line: In addition to the Office of Maternal-Child Health's four counselors, two additional bi-lingual staff were hired to respond to Hispanic and Asian callers. In addition, a TTY/TDD line was installed to facilitate the hearing impaired. Health line staff are the lifeline to the program. They are available M-F, 7:45 am-4:45 pm to answer all calls, provide assistance in completing applications and directing callers to other services that they may also be eligible for (e.g. food stamps, WIC). Counselors also provide support by attending community events to staff booths (help families complete applications on site, provide information and follow-up to ensure that applications are completed and mailed in). Healthline staff also follow-up with non-speaking families to ascertain any barriers and provide appropriate action. All problems reported to health line staff are reported to Medical Assistance Administration/Income Maintenance Administration.

- Training and Technical Assistance: Houston Associates, Inc. conducts training to service providers and the lay community to provide information on eligibility criteria, application process in its entirety and how to select benefits provided by (5) HMOs. Information on the recertification process is also included. HAI also provides assistance to participants who are interested in hosting enrollment events or activities associated with distributing information to their constituents. Training has also been provided to federal agencies (U.S. Department of Health and Human Services, U.S. Department of Education, U.S. Department of Agriculture in addition to District agencies, Community Advocacy groups–Covering Kids, Hope for Kids and others). All persons requesting applications must attend training or assign a representative from their organization to complete training.

- Media and Public Relations: Promotions have included paid radio and print advertisements and Public service announcements (PSAs) targeted to ethnic audiences; fact sheets in English, Spanish, Amaric, French, Mandarin, Vietnamese, and Lao; posters in Spanish and Mandarin; direct mail postcards to (7,000) households of free and reduced lunch students, 20,000 to high school students; mailers to 400 day care providers, 1,000 targeted community and business packets.

- Outreach Activities: Range from partnerships with over 800 organizations, businesses, community-based organizations, public, private and charter schools, and day care

providers on an ongoing basis. Applications are available at each of these sites. The public is directed to these convenient locations that are accessible during the course of their workday: CVS/Pharmacy, RiteAid, Giant, Safeway, local libraries, Department of Motor Vehicles Service Centers, Employment centers, Department of Health sites, Housing Department and Tax and Revenue office. Covering Kids-- three community-based sites, Public Benefit Corporation-- (8 sites), Not-for-profit clinic consortium-- (5) sites all provide applications and on-site face-to-face assistance. Managed-care organizations have also partnered to support hundreds of community events, direct mail and radio/print advertisements.

Targeted outreach and marketing efforts (face-to-face contact) has been conducted with merchant associations, DC Chamber, Ibero Chamber, Asian business community, and welfare-to-work contractors. Street outreach is also conducted in targeted areas each week. Health line staff are assigned to locations to distribute materials. Special outreach efforts have also begun with faith-based community and day care providers to increase their participation (e.g. HAI staff target churches to distribute information, direct mailers and conduct on-site enrollment during regularly scheduled events); a staff person has been dedicated to working with 350 day care providers. A partnership between the DC Office of Early Childhood Education was developed in June to conduct on-site enrollment at selected sites, monthly direct mailers, and phone calls are placed to directors of each site periodically as a reminder.

Schools, day care providers and student health centers at the local universities have partnered with the District to target over 100,000 children under age 19, parents and pregnant women. Ongoing activities are planned each year to better coordinate efforts and maximize staffing including our volunteer base.

Effectiveness has been measured as previously stated in section 2.4, A.

C. Which methods best reached which populations? How have you measured effectiveness?

Response: The following quality improvement measures were continued in FY 2001:

- Conducted focus groups of eligibles to ascertain their level of awareness and knowledge of the program.
- Information obtained from the focus groups was instrumental in the redesigning of our application to reflect “family size” instead of household size, the government bars were offensive and looked too much like a public program, a new logo was designed to create a “human” feeling with the campaign, the application was reformatted to place directions in a more focal area; relationship for benefits boxes were created; the section for social security number provided an option (X) for use by the District's expansion of non-citizen children; the income box reflected other choices than weekly and monthly; bolder type was used to emphasis sections; additional explanations and examples were provided to make families more at ease in providing information resulting in completed applications.
- Health line staff received intensive training (e.g. street outreach, data collection,

telephone marketing); staff was also assigned to sites in the community to increase visibility, distribute applications and provide face-to-face assistance. We are able to correlate increases in call volumes to specific outreach activities and/or media advertisements over a period of time that resulted in increased enrollment.

- Outreach representatives were assigned to schools and day care providers to conduct enrollment events at existing activities. Contests and incentives were offered. Less paper was sent home with kids to lose. Direct mail was utilized to reach parents in addition to more face-to-face contact at targeted schools during registration; report card pick-up days, career days, health fairs sponsored by these groups and collateral materials were distributed to home room teachers.

- Through extensive partnerships with community-based organizations that provide services to the immigrant community, Covering Kids and our (2) bi-lingual health line counselors, the outreach contractor coordinates and participates in outreach efforts. This includes attendance at community events and providing technical assistance and training to service providers and community leaders. A significant increase in Asian callers has resulted through these efforts.

Effectiveness has been measured as previously stated in section 2.4, A.

2.5 Retention:

A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

Response: 12-month recertification period with self reporting in changes in eligibility. Reminder notices are generated by the Income Maintenance Administration (IMA) as well as by the SCHIP outreach contractor.

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

___ Follow-up by caseworkers/outreach workers
_X_ Renewal reminder notices to all families
___ Targeted mailing to selected populations, specify population
___ Information campaigns
___ Simplification of re-enrollment process, please describe
___Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe
___ Other, please explain

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

Response: Yes.

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

Response: When children are recertified in a timely fashion, there is a better chance that continuously eligible children will remain in SCHIP and therefore benefit from continuity of care.

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

Response: No data is collected on this.

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

Response: Yes. Screening is first done to determine Medicaid eligibility and then SCHIP eligibility.

B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

Response: Children are usually in the SCHIP program for at least 3 months, even if there has been a decrease in the household earnings. Upon that 3-month update, a child whose eligibility status has changed will simply have his/her program code changed, which goes unnoticed by the recipient.

C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Response: Yes. The SCHIP program falls under the Medicaid Managed Care Program with respect to delivery systems, therefore the same MCOs and provider networks are used.

2.7 Cost Sharing:

A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

Response: N/A

B. Has your State undertaken any assessment of the effects of cost sharing on utilization of health service under SCHIP? If so, what have you found?

Response: N/A

2.8 Assessment and Monitoring of Quality of Care:

A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

Response: SCHIP enrollees are essentially Medicaid Managed Care Program enrollees whose records are audited by an external reviewer. This audit is performed annually however SCHIP enrollee information is not extracted from the overall Medicaid managed care program enrollee. The Quality Assurance Unit within MAA reviews these audits for information such as:

- Appointment audits
- PCP/enrollee ratios
- Time/distance standards
- Urgent/routine care access standards
- Network capacity reviews
- Complaint/grievance/disenrollment reviews
- Case file reviews
- Beneficiary surveys
- Utilization analysis

B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

Response: The annual external auditor compiles information on well-baby care, well-child care, immunizations, dental and vision care (as stated in section 2.8, A). Mental health and substance abuse counseling is monitored directly by the Quality Assurance Unit within MAA.

C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

Response: Outreach broker is undertaking focus groups to assess consumer satisfaction with quality care and the health care delivery system from enrollment to point-of-service and re-enrollment.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

A. Eligibility

Response: The District continues to experience problems with continuity of care due to recertification of recipients. Although recertification notices are forwarded along with reminder notices, too many recipients are still losing Medicaid by not recertifying in a timely manner.

B. Outreach

Response: The successes of the program have been based on partnerships, accessibility of applications throughout the community, media and promotional materials, a professional, customer-focused health line, face-to-face marketing, training and technical assistance provided to targeted populations. The District's outreach program has been based on social marketing strategies. These strategies have proven successful in most instances, however, we still find that there are many families who still are not aware of the program. The challenged this presents to us relies on intensifying advertising as we have with our partnership and other targeted outreach activities. It is the cumulative effect of all these social marketing tools operating in concert that will over time encourage families to think health prevention and to apply and re-apply.

<u>Barriers</u>

- Simplification of re-certification (Have applicant review, make changes if any; if not they do not need to send anything back. They are automatically re-certified)
- Employers failure to reveal if they provide insurance to employees.
- Eligibles do not fully understand the value of health insurance, even if it's presented to them as FREE.
- Lack of presumptive eligibility
- Inability to apply online due to requirement for supporting documentation.
- Immigration status. Lack of trust by immigrant population of government sponsored programs. Immigrant parents with American born children are distrustful of programs because of they fear being reported to INS. (They would risk children having no health insurance rather than risk deportation.) Many of the community-based organizations that work with this community have been helpful in advocating the program, however, an equal number of the same advise immigrants enrolling in government programs.
- Reporting of caretaker/relative information on application. Caretakers may not have legal custody and fear children being taken away from them and placed in foster care.

- Reporting of absent father's information. Families fear that this information will be reported to the courts; retaliation from absent father; cultural and religious issues associated with marital status especially in immigrant families.
- Reporting income for families who work seasonally or sporadically-income may vary and it is difficult to report monthly and annually.
- Re-certification at local service centers-staff at local service centers may not be as knowledgeable as staff at central office.

TANF population still is not aware that they may be eligible because service centers do not always inform them.

C. Enrollment

Response: The District is still encountering problems with overall enrollment numbers for the SCHIP. Although, the overall Medicaid numbers have increased as a result of all of the efforts underway for SCHIP, the fact that SCHIP for D.C. is an expansion has been a barrier in increasing actual SCHIP numbers.

D. Retention/disenrollment

Response: Again, retention and disenrollment have proven to be consistent barriers for the District and Medicaid. Recertification has been acknowledged, by most, as playing the biggest role in the disenrollment of large numbers of beneficiaries.

E. Benefit structure **N/A**

F. Cost-sharing **N/A**

G. Delivery system **N/A**

H. Coordination with other programs **N/A**

I. Crowd-out **N/A**

J. Other **N/A**

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.

N*ote: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).*

	Federal Fiscal Year 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs			
Insurance payments			
Managed care	2,976,471	3,155,059	3,218,160
per member/per month rate X # of eligibles			
Fee for Service	1,621,967	1,654,406	1,687,494
Total Benefit Costs	4,598,438	4,809,465	4,905,654
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	4,598,438	4,809,465	4,905,654
Administration Costs			
Personnel	44,061	61,069	61,680
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs	407,510	419,877	428,885
Other			
Total Administration Costs	451,571	480,946	490,565
10% Administrative Cost Ceiling	459,844	480,946	490,565
Federal Share (multiplied by enhanced FMAP rate)	5,050,009	5,290,411	5,396,219
State Share	1,342,407	1,406,312	1,434,438
TOTAL PROGRAM COSTS	6,392,416	6,696,723	6,830,657

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

Response: N/A

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

__X__ State appropriations
_____ County/local funds
_____ Employer contributions

_____Foundation grants
_____Private donations (such as United Way, sponsorship)
_____Other (specify)

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures?

Response: No.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name	DC Healthy Families	
Provides presumptive eligibility for children	__X__No _____Yes, for whom and how long?	_____No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No __X__Yes, for whom and how long? SCHIP population; 3 months retroactive eligibility	_____No _____Yes, for whom and how long?
Makes eligibility determination	__X__State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*
Average length of stay on program	Specify months 12	Specify months
Has joint application for Medicaid and SCHIP	_____No __X__Yes	_____No _____Yes
Has a mail-in application	_____No __X__Yes	_____No _____Yes
Can apply for program over phone	__X__No _____Yes	_____No _____Yes
Can apply for program over internet	__X__No _____Yes	_____No _____Yes
Requires face-to-face interview during initial application	__X__No _____Yes	_____No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	__X__No _____Yes, specify number of months What exemptions do you provide?	_____No _____Yes, specify number of months What exemptions do you provide?
Provides period of continuous coverage regardless of income changes	_____No __X__ Yes, specify number of months Explain circumstances when a child would lose eligibility during the time period 12 months, unless the child moves or withdraws from the program.	_____No _____Yes, specify number of months Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or	__X__No	_____No

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
enrollment fees	_____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)	_____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)
Imposes copayments or coinsurance	_X_No _____Yes	_____No _____Yes
Provides preprinted redetermination process	_X_ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	_____ No _____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

Response: Two differences in the initial application and redetermination process include:

- Enrollees requiring a redetermination are not required to fill out another application and;
- Don't have to have their demographics (e.g.; social security number, date of birth) verified again.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher

_200% of FPL for children under age __21 __
____% of FPL for children aged _____
____% of FPL for children aged _____

Medicaid SCHIP Expansion

200_% of FPL for children aged __under 19 _
____% of FPL for children aged _____
____% of FPL for children aged _____

Separate SCHIP Program

____% of FPL for children aged _____
____% of FPL for children aged _____
____% of FPL for children aged_____

6.2 As of September 30, 2001, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)?

____ Yes _X__ No

If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	Separate SCHIP Program
Earnings	$90	$N/A	$N/A
Self-employment expenses	$	$N/A	$N/A
Alimony payments Received	$	$N/A	$N/A
Paid	$	$N/A	$N/A
Child support payments Received	$N/A	$N/A	$N/A
Paid	$N/A	$N/A	$N/A
Child care expenses	$200 for children under age 1; $175 for children over 1	$N/A	$N/A
Medical care expenses	$ Spend down	$N/A	$N/A
Gifts	$N/A	$N/A	$N/A
Other types of disregards/deductions (specify)	$ Earned income=$30 disregard + 1/3 of remainder for 4 months	$N/A	$N/A

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

_X__No ___Yes, specify countable or allowable level of asset test_____

Medicaid SCHIP Expansion program

__X_No____Yes, specify countable or allowable level of asset test_____

Separate SCHIP program

__X_No____Yes, specify countable or allowable level of asset test_____

Other SCHIP program_____

_XNo____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2001?

___ Yes _X__ No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

A. Family coverage **N/C**

B. Employer sponsored insurance buy-in **N/C**

C. 1115 waiver

D. Eligibility including presumptive and continuous eligibility **N/C**

E. Outreach **N/C other than those listed in section 2.4 Outreach.**

F. Enrollment/redetermination process **N/C**

G. Contracting **N/C**

H. Other **N/C**